

affected more than men; and 2) QOL impacts of obesity decline with age. Qualitative work during the development of the Obesity and Weight Loss Quality-of-Life Measure (OWLQOL) indicated that these assumptions may not necessarily be completely valid. We explore the degree to which weight-related quality of life varies between gender and across age groups. **METHODS:** Through Knowledge Networks, a web-based TV survey panel similar to the national population, an adult sample (age > 20) of 1342 obese persons (BMI \geq 30) was prospectively and randomly selected. Quality of life was measured by the total summary score and four subdomain scores of the OWLQOL. QOL scores were plotted by age and gender. Analysis of variance was used to examine the significance of the differences between group means. **RESULTS:** The greatest disparities in QOL scores by gender appear in the younger (20–35) age group where the mean OWLQOL score for males was 82.7, and only 58.4 for females ($F = 75.6$; $P < 0.001$). The smallest gender differences between mean scores was demonstrated in the oldest (66+) group (87.3 for males and 77.7 for females ($F = 11.5$; $P = 0.001$)). When assessing QOL scores separately by gender, the differences between age groups are only significant within the female group ($P < 0.01$). **CONCLUSIONS:** The significant differences in weight-related quality of life (24.3 point difference in the younger group and 9.6 for the oldest group) tend to be masked when looking only at combined group totals. Evidence from this data suggests that women are affected differently by obesity than men (but more so in the younger age groups) and that negative QOL impacts from obesity do lessen with age, but these differences are only significantly different for female populations.

PCV49**COMPARISON OF WEIGHT-RELATED SYMPTOMS AND QUALITY-OF-LIFE IMPACTS BY BODY MASS INDEX**

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OBJECTIVE: Adults who are overweight or obese are at greater risk for other serious health conditions and self-report a variety of negative impacts on quality of life, including low self-esteem, social stigma and many bothersome physical symptoms. This analysis explores the relationship between symptoms and physically linked quality-of-life scores with comparisons made between BMI levels. **METHODS:** Through Knowledge Networks, a web-based TV survey panel similar to the national population, an adult sample of 1348 obese persons (BMI 30 or higher) and 1157 persons (BMI less than 30) were prospectively and randomly selected. Using the newly developed Weight-Related Symptom Measure (WRSM), we obtained self-reported data for a list of 20 physical symptoms. Quality of life was measured by the Obesity and Weight Loss Quality of Life Measure (OWLQOL).

For each symptom, we identified the differences in the physical health subscale of the OWLQOL for those reporting and not reporting the symptom and then compared those results between BMI groups. **RESULTS:** For all symptoms, there was a significant difference in scores on the physical health subscale of the OWLQOL between those who reported the symptom (55.9 to 89.7) and those who did not (73.8 to 95.9), indicating higher quality of life for those not reporting symptoms. Those reporting each symptom demonstrated highly significant differences between high (55.9 to 69.2) and low BMI groups (82.5 to 89.7) for physical health related QOL, indicating higher QOL for those with lower BMI levels. **CONCLUSIONS:** While the physical symptoms that occur frequently in obese populations can also be experienced by those with low BMI scores, there is a far greater tendency for them to be reported in individuals with BMI scores greater than 30, and a significantly greater negative impact of these same symptoms on the QOL of those who have BMI scores of 30 or more.

PCV50**DESCRIPTION AND PREDICTIVE MODELING OF PERCEIVED WORK PERFORMANCE IN AN ACUTE CORONARY SYNDROME POPULATION**

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OBJECTIVE: To describe perceived work performance of patients with the diagnosis of acute coronary syndrome (ACS) and to determine predictive relationships of several patient-specific independent variables. **METHODS:** All ACS patients discharged from a university affiliated hospital during a 3-year period were mailed a questionnaire that included the Work Performance Scale (WPS). Independent variables included the SF-8 (PCS-8, MCS-8), the EQ-5D General Health Visual Analog Scale (VAS), cardiac functional status [Duke Activity Status Index (DASI)], symptom count (Symptom Distress Checklist), comorbidity index (Charlson self-administered), patient-perceived cardiac disease severity, medication count, compliance score, job satisfaction, current employment duration, patient demographics, and ACS type [unstable angina (UA) or myocardial infarction (MI)]. This analysis includes respondents who indicated current employment. Stepwise-elimination ($p < 0.05$) linear regression models determined the combined predictive ability of independent variables on WPS. Due to the high correlation between the PCS-8, VAS, and DASI, three separate models were used with each one as a predictor variable. **RESULTS:** To date, 414 of 1230 patients (34%) have responded, including 122 (29.5%) currently working. Current workers averaged 57.6(\pm 8.6) years of age; 80.3% male; 94.3% Caucasian; 69.2% history of MI; 13.4% severe or worse perceived cardiac disease severity. Respondents reported the following mean(s.d.) responses: DASI 26.0(\pm 7.4); comorbidity index 1.7(\pm 1.4); medica-

tions 7.2(\pm 4.1); compliance score 4.8(\pm 0.6); symptoms 6.2(\pm 4.4); PCS-8 59.2(\pm 7.9); MCS-8 51.2(\pm 8.1); and VAS 82.4(\pm 16.0). The mean WPS was 4.6(\pm 0.5); mean employment duration of 14.6(\pm 12.3) years and 2.5% reporting job dissatisfaction. Of the 3 models tested, that with the highest explanatory ability (r -square = 0.36) included number of symptoms, age, perceived cardiac severity, and PCS-8, with more symptoms, higher perceived severity, higher age, and lower PCS-8 scores associated with lower perceived work performance. **CONCLUSIONS:** Currently employed ACS patients report a high level of work performance. Symptomology, perceived disease severity, age, and physical function appear to be associated with work performance.

PCV51

PREDICTIVE MODELS OF HEALTH-RELATED QUALITY OF LIFE UTILIZING PATIENT REPORTED OUTCOMES DATA FROM A POPULATION WITH A HISTORY OF ACUTE CORONARY SYNDROME

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OBJECTIVE: To model the predictive relationships of self-reported patient-specific, independent predictor variables on dependent health-related quality of life measures (HRQL) in an acute coronary syndrome (ACS) population. **METHODS:** All ACS patients discharged from a university affiliated hospital during a 3-year period were mailed a questionnaire that included two short general HRQL measures, the SF-8 and EQ-5D. Independent variables included cardiac functional status [Duke Activity Status Index (DASI)], symptom count (Symptom Distress Checklist), comorbidity index (Charlson self-administered), patient-perceived cardiac disease severity, medication count, compliance score, patient demographics, and ACS type [unstable angina (UA) or myocardial infarction (MI)]. Three separate stepwise-elimination ($p < 0.05$) linear regression models determined the combined predictive ability of independent variables on the PCS-8, the MCS-8, and the EQ-5D General Health Visual Analog Scale (VAS). **RESULTS:** To date, 414 of 1230 patients (34%) have responded. The mean (\pm s.d.) age was 65.7(\pm 11.3) years; 67.7% male; 94.0% Caucasian; 62.1% history of MI; and 22.9% reported severe or worse cardiac disease severity. Respondents reported the following mean (\pm s.d.) responses: DASI 20.5(\pm 8.1); comorbidity index 2.5(\pm 1.9); number of medications 8.4(\pm 4.6); compliance score 4.8(\pm 0.5); number of symptoms 7.8(\pm 4.9); PCS-8 53.7(\pm 10.5); MCS-8 49.5(\pm 9.5); and VAS 73.6(\pm 20.5). The final PCS model had an r -square of 0.51 and contained the comorbidity index, number of symptoms, age, gender, perceived cardiac severity, household income, and type of ASC. The final MCS-8 model had an r -square of 0.36 and contained number of symptoms, perceived cardiac severity, and

education level. The final VAS model had an r -square of 0.49 and contained comorbidity index, number of symptoms, perceived cardiac severity, and household income level. **CONCLUSIONS:** Patient self-reported measures of disease, cardiac functional status, symptomology, and medication utilization formed highly predictive models of HRQL. Greater numbers of reported symptoms and higher patient-perceived cardiac severity were associated with lower HRQL in all three models.

PCV52

WHICH STATIN? A MULTICRITERIA DECISION ANALYSIS

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OBJECTIVE: The five statins currently available in the US (atorvastatin [A], pravastatin [P], simvastatin [S], fluvastatin [F] and lovastatin [L]) differ in terms of their abilities to lower LDL-C, the need to adjust dosing for decreased renal function, potential for drug-drug interactions, cost, recommended hepatic function monitoring schedule, and level of proven effectiveness. The implications of these differences on the clinical use of statins have been largely unexplored. The purpose of this study was to examine the effects of these intra-class differences on clinical decision making using multicriteria decision analysis. **METHODS:** A multicriteria decision analysis using the Analytic Hierarchy Process (AHP) was performed from the practitioner's perspective. The goal was defined as "Choose the best statin". Decision criteria were based on the differences mentioned above. Costs were included in the analysis both as internet drug store prices (scenario 1) and in terms of patient co-pays for 3 current three-tiered managed care formularies in Rochester, NY (scenarios 2,3, & 4). Data comparing the statins' performance on the other criteria were obtained from the literature. **RESULTS:** Statin priority scores, which measure the relative rankings of the alternatives' abilities to meet the all decision criteria (higher scores are better), for the 4 scenarios are: Scenario 1: L = 0.214, F = 0.209, P = 0.200, S = 0.190, A = 0.187; Scenario 2: P = 0.209, L = 0.208, S = 0.205, F = 0.192, A = 0.188; Scenario 3: P = 0.213, L = 0.208, S = 0.200, A = 0.192, F = 0.187; Scenario 4: P = 0.209, L = 0.208, S = 0.205, A = 0.192, F = 0.187. In addition to cost, relative priority scores in all scenarios were affected by differences in the importance assigned to ability to lower LDL-C, ease of prescribing safely, and proven effectiveness. **CONCLUSION:** The relative importance of differences among statins has a significant impact on optimal clinical use of these drugs. These results suggest that practitioners should be aware of these differences and incorporate them in clinical decisions regarding statin prescriptions.